Clinical Breast Exam (CBE) encounter
Office Visit for Pap Test, no CBE Done encounter

CPT CODE	Code Descriptions	Billing Guidelines
99201	New patient visit, *problem focused history*	• For an office visit with Clinical Breast Exam or Clinical Breast Exam and Pap test, use the Clinical Breast Exam (CBE) Office Visit encounter • For an office visit without CBE (Pap test only), use the Office Visit for Pap Test, no CBE Done encounter, for example short term follow-up Pap test or CBE refusals • CDC requires that every patient be offered self-breast exam instruction yearly at the primary clinic • Breast screening services must include a Clinical Breast Exam unless there is a documented refusal in the patient's chart • Office visits should only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN or PA • The CPT code billed for an office visit should be based on the level of complexity of the history, exam and decision-making, NOT on time spent with the patient • EDW can only be billed for the portion of the office visit that directly pertains to breast and/or cervical cancer screening. Providers cannot bill for any portion of the office visit that relates to other conditions such as hypertension, diabetes, high cholesterol, family planning, etc. • Only one office visit is billable to EDW per day • Mammography facilities cannot bill for office visits • Neither the program, nor the patient, can be billed for "no show" EDW visits • No payment for an office visit for a pelvic exam without a CBE or Pap test
99202	New patient visit, *expanded problem focused history*	
99203	New patient visit, *detailed history*	
99211	Established patient, *problem focused history*	
99212	Established patient, *expanded problem focused history*	
99213	Established patient, *detailed history*	

First Mammogram encounter
Additional Mam Views encounter

CPT CODE	Code Descriptions	Billing Guidelines
77057	Screening mammogram, film	• Screening mammograms must be ordered by the primary clinic. A patient may not self-refer • A screening mammogram, on occasion, may precede the Clinical Breast Exam, i.e. mobile mammography events • An imaging/mammography/radiology facility may not bill for office visits • Computer Aided Detection (CAD), ductograms, galactograms, 3-D mammography, thermography, MRI, and skin biopsies are specifically not payable by EDW • BRCA -1 or other genetic testing is not payable by EDW • Only one First Mammogram encounter is entered per cycle. The Additional Mammogram encounter is used for subsequent breast mammography diagnostics • Screening and diagnostic mammograms cannot be billed the same day. A bilateral mammogram can be billed for a unilateral diagnostic conducted the same day as the screening mammogram • A diagnostic mammogram may be performed as the first mammogram for women with cosmetic/reconstructive implants and/or a history of breast cancer/lumpectomy • A diagnostic mammogram may be performed with a CBE result of discrete palpable mass (Dx benign) • A diagnostic mammogram or ultrasound must be performed with a CBE result of any of the following: Bloody/serous nipple discharge; Discrete palp mass - suspicious for Ca+; Nipple/areolar scaliness; Skin dimpling/retraction • An ultrasound is required with a CBE result of Discrete palpable mass - suspicious for Ca+
77057TC	*Technical component*	
77057PC	*Professional component*	
77056	Diagnostic bilateral mammogram, film	
77056TC	*Technical component*	
77056PC	*Professional component*	
77055	Diagnostic unilateral mammogram, film	
77055TC	*Technical component*	
77055PC	*Professional component*	
G0202	Screening mammogram, digital	
G0202TC	*Technical component*	
G0202PC	*Professional component*	
G0204	Diagnostic bilateral mammogram, digital	
G0204TC	*Technical component*	
G0204PC	*Professional component*	
G0206	Diagnostic unilateral mammogram, digital	
G0206TC	*Technical component*	
G0206PC	*Professional component*	

Ultrasound encounter

CPT CODE	Code Descriptions	Billing Guidelines
76641	Diagnostic ultrasound, complete	• May be billed on the same day as a screening mammogram or a diagnostic mammogram • An ultrasound is required with a CBE result of Discrete palpable mass - suspicious for Ca+ • 76641 is a complete examination of the breast including all four quadrants of the breast and retroareolar region. • 76642 is a focused ultrasound of the breast limited to the assessment, but not all four quadrants.
76641TC	*Technical component*	
76641PC	*Professional component*	
76642	Diagnostic ultrasound, limited	
76642TC	*Technical component*	
76642PC	*Professional component*	

Pap Test encounter

CPT CODE	Code Descriptions	Billing Guidelines
88164	Pap test, cervical, conventional slides, reported using Bethesda System, manual screening under physician supervision	• Pap tests are subject to frequency guidelines as set forth by ASCCP. Pap tests outside of guidelines require justification • Next EDW payable Pap test as calculated on the Enrollment encounter is based on said ASCCP algorithms • If most recent Pap is negative and all previous Paps are negative then the next EDW payable Pap would be in 3 years • If a CBE is not done, the office visit for the Pap test is billed using the Office Visit for Pap Test, no CBE Done encounter • If the Pap test encounter is being entered by the lab, the Clinic providing the pelvic exam may indicate pelvic exam results using the Pelvic Exam Encounter. No payment is made for pelvic exams only • EDW does not pay for routine Pap tests for women under 40. However, with a documented abnormal Pap result (ASCUS, + HPV, LSIL, HSIL) the woman may be enrolled after speaking to an EDW nurse and meeting all other EDW enrollment criteria • EDW does pay for Pap tests for women who have had a hysterectomy due to cancer and a partial cervix, but not for women with hysterectomy not due to cancer or having no cervix
88165	Pap test, cervical, conventional slides, reported using Bethesda system, manual screening and rescreening under physician supervision	
88142 88143 88174 88175	Pap test, cervical, liquid-based, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	

HPV Test encounter

CPT CODE	Code Descriptions	Billing Guidelines
87624	Lab, HPV, amplified probe technique	• Must occur with Pap test co-testing • With a negative Pap test and a negative HPV co-test, the next EDW payable Pap test would be in 5 years

Cytopathology encounter

CPT CODE	Code Descriptions	Billing Guidelines
88141	Cytopathology, cervical or vaginal, requiring interpretation by physician	• Only abnormal or reparative/reactive Pap test results are subject to physician review (ASCUS or above) • Cytopathology for quality control is not billable to EDW

Gynecologic Referral encounter
Referral Follow-Up - No Results encounter

CPT CODE	Code Descriptions	Billing Guidelines
99201	New patient visit, *problem focused history*	• Office visits should only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN or PA • The CPT code billed for an office visit should be based on the level of complexity of the history, exam and decision-making, NOT on time spent with the patient • Only one office visit is billable to EDW per day • Neither the program, nor the patient, can be billed for "no show" EDW visits • Global fee periods apply to certain diagnostic surgical procedures. Office visits may not be billed separately during the global fee period • 99204, 99205, 99214, 99215 are paid at the corresponding 99203 or 99213 amounts
99202	New patient visit, *expanded problem focused history*	
99203	New patient visit, *detailed history*	
99211	Established patient, *problem focused history*	
99212	Established patient, *expanded problem focused history*	
99213	Established patient, *detailed history*	

Cold Knife Cone (CKC) encounter

CPT CODE	Code Descriptions	Billing Guidelines
57520	Conization of cervix, with or without fulguration, with or without dilation & currettage, with or without repair; cold knife or laser (performed in office or treatment room)	• Requires prior authorization from the EDW Clinical Nurse Manager • 57520/57520F may be billed only once • May NOT be billed with colposcopy and their associated facility codes • Office visits on the day before and the day of the procedure are covered under global days (Global fee period 000) • Use 57520FF to bill for the facility fee when 57520F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88307 may be billed with 57520/57520F for up to 4 cassettes • May NOT be billed with 88305 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen. • ANESTH may be billed with 57520F
57520F	Conization of cervix, with or without fulguration, with or without dilation & currettage, with or without repair; cold knife or laser (performed in a certified ASC or facility surgical suite)	
57520FF	*Facility fee*	
88307	Surgical pathology, gross & microscopic exam requiring microscopic evaluation of surgical margins	
88307TC	*Technical component*	
88307PC	*Professional component*	
ANESTH	General anesthesia	
57461	Colposcopy with loop electrode conization of the cervix (performed in office or treatment room)	• Requires prior authorization from the EDW Clinical Nurse Manager • 57461/57461F may be billed only once • Office visits on the day before and the day of the procedure are covered under global days (Global fee period 000) • Use 57461FF to bill for the facility fee when 57461F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88307 may be billed with 57461/57461F for up to 4 cassettes • May not be billed with 88305 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen. • ANESTH may be billed with 57461F
57461F	Colposcopy with loop electrode conization of the cervix (performed in a certified ASC or facility surgical suite)	
57461FF	*Facility fee*	
88307	Surgical pathology, gross & microscopic exam requiring microscopic evaluation of surgical margins	
88307TC	*Technical component*	
88307PC	*Professional component*	
ANESTH	General anesthesia	

Colposcopy with Biopsy Encounter

CPT CODE	Code Descriptions	Billing Guidelines
57455	Colposcopy of the cervix, with biopsy (performed in office or treatment room)	• 57455/57455F may be billed only once • Office visits on the day before and the day of the procedure are covered under global days (Global fee period 000) • Use 57455FF to bill for the facility fee when 57455F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88305 may be billed with 57455/57455F for up to 4 cassettes • May NOT be billed with 88307 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen.
57455F	Colposcopy of the cervix, with biopsy (performed in a certified ASC or facility surgical suite)	
57455FF	*Facility fee*	
88305TC	*Technical component*	
88305PC	*Professional component*	
58110	Endometrial sampling performed in conjunction with colposcopy	• Requires prior authorization from the EDW Clinical Nurse Manager without an AGC pap • 58110/58110F may be billed only once • Office visits on the day of the procedure are covered under global days (Global fee period 000) • Use 581100FF to bill for the facility fee when 58110F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88305 may be billed with 58110/58110F for up to 4 cassettes • May NOT be billed with 88307 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen.
58110F	Endometrial sampling performed in conjunction with colposcopy (performed in a certified ASC or facility surgical suite)	
88305	Surgical pathology, gross & microscopic exam	
88305TC	*Technical component*	
88305PC	*Professional component*	

Colposcopy with ECC encounter

CPT CODE	Code Descriptions	Billing Guidelines
57454	Colposcopy of the cervix, with biopsy & endocervical curettage (performed in office or treatment room)	• 57454/57454F may be billed only once • Office visits on the day of the procedure are covered under global days (Global fee period 000) • Use 57454FF to bill for the facility fee when 57454F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88305 may be billed with 57454/57454F for up to 4 cassettes • May NOT be billed with 88307 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen.
57454F	Colposcopy of the cervix, with biopsy & endocervical curettage (performed in a certified ASC or facility surgical suite)	
57454FF	*Facility fee*	
88305	Surgical pathology, gross & microscopic exam	
88305TC	*Technical component*	
88305PC	*Professional component*	
57456	Colposcopy of the cervix, with endocervical curettage (performed in office or treatment room)	• 57456/57456F may be billed only once • Office visits on the day of the procedure are covered under global days (Global fee period 000) • Use 57456FF to bill for the facility fee when 57456F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88305 may be billed with 57456/57456F only once • May not be billed with 88307 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen.
57456F	Colposcopy of the cervix, with endocervical curettage (performed in a certified ASC or facility surgical suite)	
57456FF	*Facility fee*	
88305	Surgical pathology, gross & microscopic exam	
88305TC	*Technical component*	
88305PC	*Professional component*	

Colposcopy without Biopsy encounter

CPT CODE	Code Descriptions	Billing Guidelines
57452	Colposcopy of the cervix, without biopsy (performed in office or treatment room)	• 57452/57452F may be billed only once • Office visits on the day of the procedure are covered under global days (Global fee period 000) • Use 57452FF to bill for the facility fee when 57452F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • May NOT be billed with 88305 or 88307
57452F	Colposcopy of the cervix, without biopsy (performed in a certified ASC or facility surgical suite)	
57452FF	*Facility fee*	

Endocervical Curettage (ECC) encounter

CPT CODE	Code Descriptions	Billing Guidelines
57505	Endocervical curettage (not done as part of a dilation & curettage) (performed in office or treatment room)	• 57505/57505F may be billed only once • Office visits on the day of the procedure and during the 10 day post-operative period are covered under global days (Global fee period 010) • Use 57505FF to bill for the facility fee when 57505F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88305 may be billed with 57505/57505F only once • May NOT be billed with 88307 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen.
57505F	Endocervical curettage (not done as part of a dilation & curettage) (performed in a certified ASC or facility surgical suite)	
57505FF	*Facility fee*	
88305	Surgical pathology, gross & microscopic exam	
88305TC	*Technical component*	
88305PC	*Professional component*	

Other Biopsy - not Colposcopic encounter

CPT CODE	Code Descriptions	Billing Guidelines
57500	Biopsy, single or multiple, or local excision of lesion, with or without fulgaration (performed in office or treatment room)	• 57500/57500F may be billed only once • Office visits on the day of the procedure are covered under global days (Global fee period 000) • Use 57500FF to bill for the facility fee when 57500F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88305 may be billed with 57500/57500F for up to 4 cassettes • May NOT be billed with 88307 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen.
57500F	Biopsy, single or multiple, or local excision of lesion, with or without fulgaration (performed in a certified ASC or facility surgical suite)	
57500FF	*Facility fee*	
88305	Surgical pathology, gross & microscopic exam	
88305TC	*Technical component*	
88305PC	*Professional component*	
58100	Endometrial sampling with or without endocervical sampling, without cervical dilation, any method, separate procedure (performed in office or treatment room)	• 58100/58100F may be billed only once • Office visits on the day of the procedure are covered under global days (Global fee period 000) • Use 58100FF to bill for the facility fee when 58100F is performed in a certified ASC or a facility surgical suite • Procedure or treatment rooms do not qualify for the facility fee payment • 88305 may be billed with 58100/58100F only once • May NOT be billed with 88307 • Each pathology cassette may contain multiple specimens. Billling is by cassette NOT specimen.
58100F	Endometrial sampling with or without endocervical sampling, without cervical dilation, any method, separate procedure (performed in a certified ASC or facility surgical suite)	
58100FF	*Facility fee*	
88305	Surgical pathology, gross & microscopic exam	
88305TC	*Technical component*	
88305PC	*Professional component*	

LEEP (Diagnostic) encounter

CPT CODE	Code Descriptions	Billing Guidelines
57460	Colposcopy of the cervix with loop electrode biopsy(s) of the cervix (performed in office or treatment room)	• Requires prior authorization from the EDW Clinical Nurse Manager • 57460/57460F may be billed only once, regardless of number of lesions • Office visits on the day of procedure are NOT payable. (Global fee period 000) • Procedure rooms or treatment rooms do not qualify for the facility fee payment • Use 57460FF to bill for the facility fee when 57460F performed in a certified ASC or a facility surgical suite • 88307 may be billed for up to 4 cassettes. May NOT be billed with 88305
57460F	Colposcopy of the cervix with loop electrode biopsy(s) of the cervix (performed in a certified ASC or facility surgical suite)	
57460FF	*Facility fee*	
88307	Surgical pathology, gross & microscopic exam requiring microscopic evaluation of surgical margins	
88307TC	*Technical component*	
88307PC	*Professional component*	
57522	Loop electrode excision (performed in office or treatment room)	• Requires prior authorization from the EDW Clinical Nurse Manager • May be billed only once, regardless of number of lesions • Office visits the day before the procedure and the 90-day postoperative period are covered under global days • Use 57522FF to bill for the facility fee when 57522F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 88307 may be billed for up to 4 cassettes. May not be billed with 88305
57522F	Loop electrode excision (performed in a certified ASC or facility surgical suite)	
57522FF	*Facility fee*	
88307	Surgical pathology, gross & microscopic exam requiring microscopic evaluation of surgical margins	
88307TC	*Technical component*	
88307PC	*Professional component*	

Surgical Referral (Breast) encounter
Consultant Repeat CBE encounter
Referral Follow-Up - No Results encounter

CPT CODE	Code Descriptions	Billing Guidelines
99201	New patient visit, *problem focused history*	• Office visits should only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN or PA • The CPT code billed for an office visit should be based on the level of complexity of the history, exam and decision-making, NOT on time spent with the patient • Only one office visit is billable to EDW per day • Neither the program, nor the patient, can be billed for "no show" visits • Global fee periods apply to certain diagnostic surgical procedures. Office visits may NOT be billed separately during the global fee period
99202	New patient visit, *expanded problem focused history*	
99203	New patient visit, *detailed history*	
99211	Established patient, *problem focused history*	
99212	Established patient, *expanded problem focused history*	
99213	Established patient, *detailed history*	

Fine Needle Aspirate (FNA) encounter

CPT CODE	Code Descriptions	Billing Guidelines
10021	Fine needle aspiration without imaging guidance (performed in office or treatment room)	• FNA is NOT a suitable diagnostic method to definitively determine a final diagnosis of breast cancer. May not be billed to evaluate a breast mass • 88173 requires cytological expertise • Use 10021FF to bill for the facility fee when 10021F performed in a certified ASC or a facility surgical suite • Use 10022FF to bill for the facility fee when 10022F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 88305 may only be billed if tissue is present in the fine needle aspirate
10021F	Fine needle aspiration without imaging guidance (performed in a certified ASC or facility surgical suite)	
10021FF	*Facility fee*	
10022	Fine needle aspiration with imaging guidance (performed in office or treatment room)	
10022F	Fine needle aspiration with imaging guidance (performed in a certified ASC or facility surgical suite)	
10022FF	*Facility fee*	
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	
88172TC	*Technical component*	
88172PC	*Professional component*	
88173	Cytopathology, evaluation of fine needle aspirate	
88173TC	*Technical component*	
88173PC	*Professional component*	
88305	Surgical pathology, gross & microscopic exam	
88305TC	*Technical component*	
88305PC	*Professional component*	

Breast Biopsy encounter

Puncture Aspiration

CPT CODE	Code Descriptions	Billing Guidelines
19000	Puncture aspiration of cyst of breast (performed in office or treatment room)	• 19000/1900F may be billed once per breast, regardless of the number of lesions • May be billed with 76942 • 19001/19001F may be billed for up to 2 additional lesions per breast • Office visits on the day of the procedure are NOT payable (Global Fee Period 000) • Use 19000FF to bill for the facility fee when 19000F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • Pathology (88305 or 88173) may NOT be billed with 19000/19000F
19000F	Puncture aspiration of cyst of breast (performed in a certified ASC or facility surgical suite)	
19000FF	*Facility fee*	
19001	Puncture aspiration of cyst of breast, each additional. cyst (performed in office or treatment room)	
19001F	Puncture aspiration of cyst of breast, each additional. cyst (performed in a certified ASC or facility surgical suite)	

Needlecore, No Imaging Guideance

CPT CODE	Code Descriptions	Billing Guidelines
19100	Percutaneous, needlecore, not using imaging guidance (performed in office or treatment room)	• 19100/19100F may only be billed once per breast, regardless of the number of specimens • Cannot bill with 76645, 76942, or mammograms codes • Office visits on the day of the procedure are not payable (Global Fee Period 000)
19100F	Percutaneous, needlecore, not using imaging guidance (performed in a certified ASC or facility surgical suite)	• Use 19100FF to bill for the facility fee when 19100F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment
19100FF	*Facility fee*	• 88305 may be billed for up to 4 biopsy specimens per breast • ANESTH may be billed with 19100F

Needlecore, Percutaneous, Stereotactic Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19081	Biopsy, breast, w/placement of breast localization device(s) imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance (performed in office or treatment room)	• 19081/19081F may be billed only once, regardless of the number of lesions • 19082/19082F may be billed up to a maximum of 2 additional lesions per breast • May NOT be billed with 19281-19286 or associated facility codes • Cannot be billed with 76645, 76942, or mammogram codes • Office visits NOT payable on day of procedure. (Global fee period 000) • Use 19081FF to bill for the facility fee when 19081F performed in a certified ASC or a facility surgical suite • Use 19082FF to bill for the facility fee when 19082F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 88305 may be billed for up to 3 cassettes per breast • 76098 may be billed for each lesion (up to the maximum of 3), if indicated
19081F	Biopsy, breast, w/placement of breast localization device(s), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance (performed in a certified ASC or facility surgical suite)	
19081FF	*Facility fee*	
19082	Each additional lesion, including stereotactic guidance (performed in office or treatment room)	
19082F	Each additional lesion, including stereotactic guidance (performed in a certified ASC or facility surgical suite)	

Needlecore, Percutaneous, Ultrasound Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19083	Biopsy, breast, w/placement of breast localization device(s), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance (performed in office or treatment room)	• 19083 and 19083F may only be billed once per breast, regardless of the number of lesions • 19084/19084F may be billed up to the maximum of 2 additional lesions per breast • May not be billed with 19281-19286 or associated facility codes • Cannot be billed with 76645, 76942 or mammogram codes • Office visits NOT payable on day of procedure. (Global fee period 000) • Use 19083FF to bill for the facility fee when 19083F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 88305 may be billed for up to 3 biopsy specimens per breast • 76098 may be billed for each lesion (up to the maximum of 3), if indicated
19083F	Biopsy, breast, w/placement of breast localization device(s), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance (performed in a certified ASC or facility surgical suite)	
19083FF	*Facility fee*	
19084	Each additional lesion, including ultrasound guidance (performed in office or treatment room)	
19084F	Each additional lesion, including ultrasound guidance (performed in a certified ASC or facility surgical suite)	

Incisional with Mammographic Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19101	Open, incisional biopsy (performed in office or treatment room)	• 19101/19101F may only be billed once per breast, regardless of the number of lesions • May be billed with image guided preoperative placement of breast localization devices 19281-19286 and their associated facility codes • Cannot bill with 76645, 76942, or mammogram codes • Office visits on the day of the procedure and during the 10-day postoperative period are NOT payable (Global fee period 010) • Use 19101FF to bill for the facility fee when 19101F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 88305 may be billed for up to 3 biopsy specimens per breast • 76098 may be billed for each lesion up to 3 per breast • ANESTH may be billed with 19101F
19101F	Open, incisional biopsy (performed in a certified ASC or facility surgical suite)	
19101FF	*Facility fee*	
19281	Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance (performed in office or treatment room)	• May only be billed with incisional/excisional biopsy and their associated facility codes. Facility fees are included with the primary procedure code • 19281/19281F may be billed only once per breast, regardless of the number of lesions • Additional lesions may be billed up to a maximum of 2 per breast • Cannot be billed with 19081-19086 or their associated facility codes. Cannot bill with 76645, 76942, or mammogram codes • Office visits NOT payable on day of procedure. (Global fee period 000) • ANESTH cannot be billed with 19281 or 19282. ANESTH can be billed with 19281F or 19282F
19281F	Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance (performed in a certified ASC or facility surgical suite)	
19282	Each additional lesion, including mammographic guidance (performed in office or treatment room)	
19282F	Each additional lesion, including mammographic guidance (performed in a certified ASC or facility surgical suite)	

Incisional with Stereotactic Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19101	Open, incisional biopsy (performed in office or treatment room)	• 19101/19101F may only be billed once per breast, regardless of the number of lesions • May be billed with image guided preoperative placement of breast localization devices 19281-19286 and their associated facility codes • Cannot bill with 76645, 76942, or mammogram codes • Office visits on the day of the procedure and during the 10-day postoperative period are NOT payable (Global fee period 010) • Use 19101FF to bill for the facility fee when 19101F performed in a certified ASC or a facility surgical suite • 88305 may be billed for up to 3 biopsy specimens per breast • 76098 may be billed for each lesion up to 3 per breast • ANESTH may be billed with 19101F
19101F	Open, incisional biopsy (performed in a certified ASC or facility surgical suite)	
19101FF	*Facility fee*	
19283	Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance (performed in office or treatment room)	• May only be billed with incisional/excisional biopsy and associated facility codes. Facility fees are included with the primary procedure code • 19283/19283F may be billed only once per breast, regardless of the number of lesions. Use 19284/19284F to bill for sdditional lesions up to a maximum of 2 per breast • Cannot be billed with 19081-19086 or their associated facility codes • Cannot bill with 76645, 76942, or mammogram codes
19283F	Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance (performed in a certified ASC or facility surgical suite)	
19284	Each additional lesion, including stereotactic guidance (performed in office or treatment room)	
19284F	Each additional lesion, including stereotactic guidance(performed in a certified ASC or facility surgical suite)	

Incisional Biopsy with Ultrasound Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19101	Open, incisional biopsy (performed in office or treatment room)	• 19101/19101F may only be billed once per breast, regardless of the number of lesions • Cannot bill with 76645, 76942, or mammogram codes • Office visits on the day of the procedure and during the 10-day postoperative period are NOT payable (Global fee period 010) • Use 19101FF to bill for the facility fee when 19101F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 88305 may be billed for up to 3 biopsy specimens per breast • 76098 may be billed for each lesion up to 3 per breast • 19101 cannot be billed with ANESTH. 19101F can be billed with ANESTH
19101F	Open, incisional biopsy (performed in a certified ASC or facility surgical suite)	
19101FF	*Facility fee*	
19285	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance (performed in office or treatment room)	• May only be billed with incisional/excisional biopsy and their associated facility codes. Facility fees are included with the primary procedure code • 19285/19285F may be billed only once per breast, regardless of the number of lesions • Additional lesions may be billed up to a maximum of 2 per breast • Cannot be billed with 19081-19086 or their associated facility codes • Cannot bill with 76645, 76942, or mammogram codes
19285F	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance (performed in a certified ASC or facility surgical suite)	
19286	Each additional lesion, including ultrasound guidance (performed in office or treatment room)	
19286F	Each additional lesion, including ultrasound guidance (performed in a certified ASC or facility surgical suite)	

Excisional, No Marker

CPT CODE	Code Descriptions	Billing Guidelines
19120	Excision of cyst (performed in office or treatment room)	• May be billed only once per breast regardless of the number of lesions • Cannot bill with 76645, 76942, or mammogram codes • Office visit codes on the day before, the day of the procedure and during the 90-day postoperative period are NOT payable (Global fee period 090) • Use 19120FF to bill for the facility fee when 19120F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 76098 may be billed if indicated for each lesion up to the maximum of 3 per breast • 88305 may be billed for up to 4 biopsy specimens per breast
19120F	Excision of cyst (performed in a certified ASC or facility surgical suite)	
19120FF	*Facility fee*	

Excisional, Radiological Marker, Mammographic Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19125	Excision of breast lesion, identified by preoperative placement of radiological marker, open, single (performed in office or treatment room)	• 19125 may be billed only once per breast, regardless of the number of lesions • 19126 may only be billed for up to 2 additional lesions • Cannot bill with 76645, 76942, or mammogram codes • For 19125/19125F - Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090). For 19126/19126F -Codes related to another service are always included in the global period of the other service (Global fee period ZZZ) • Use 19125FF to bill for the facility fee when 19125F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 76098 may be billed if indicated for each lesion, up to the maximum of 3 • 88305 may be billed for up to 3 biopsy specimens per breast • ANESTH may be billed with 19125F
19125F	Excision of breast lesion, identified by preoperative placement of radiological marker, open, single (performed in a certified ASC or facility surgical suite)	
19125FF	*Facility fee*	
19126	Excision of breast lesion, identified by preoperative placement of radiological marker, open, each additional. lesion separately identified	
19281	Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance (performed in office or treatment room)	• May only be billed with excisional biopsy and their associated facility codes. Facility fees are included with the primary procedure code • 19281/19281F may be billed only once per breast, regardless of the number of lesions • Additional lesions may be billed up to a maximum of 2 per breast • Cannot be billed with 19081-19086 or their associated facility codes • Cannot bill with 76645, 76942, or mammogram codes
19281F	Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance (performed in a certified ASC or facility surgical suite)	
19282	Each additional lesion, including mammographic guidance (performed in office or treatment room)	
19282F	Each additional lesion, including mammographic guidance (performed in a certified ASC or facility surgical suite)	

Excisional, Radiological Marker, Stereotactic Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19125	Excision of breast lesion, identified by preoperative placement of radiological marker, open, single (performed in office or treatment room)	• 19125 may be billed only once per breast, regardless of the number of lesions • 19126 may only be billed for up to 2 additional lesions • Cannot bill with 76645, 76942, or mammogram codes • For 19125/19125F - Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are NOT payable (Global fee period 090). For 19126/19126F -Codes related to another service are always included in the global period of the other service (Global fee period ZZZ) • Use 19125FF to bill for the facility fee when 19125F performed in a certified ASC or a facility surgical suite • Procedure rooms or treatment rooms do not qualify for the facility fee payment • 76098 may be billed if indicated for each lesion, up to the maximum of 3 • 88305 may be billed for up to 3 biopsy specimens per breast • ANESTH may be billed with 19125F
19125F	Excision of breast lesion, identified by preoperative placement of radiological marker, open, single (performed in a certified ASC or facility surgical suite)	
19125FF	*Facility fee*	
19126	Excision of breast lesion, identified by preoperative placement of radiological marker, open, each add'l. lesion separately identified	
19283	Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance (performed in office or treatment room)	• May only be billed with incisional/excisional biopsy and their associated facility codes. Facility fees are included with the primary procedure code • 19283/19283F may be billed only once per breast, regardless of the number of lesions • Additional lesions may be billed up to a maximum of 2 per breast • Cannot be billed with 19081-19086 or their associated facility codes • Cannot bill with 76645, 76942, or mammogram codes
19283F	Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance (performed in a certified ASC or facility surgical suite)	
19284	Each additional lesion, including stereotactic guidance (performed in office or treatment room)	
19284F	Each additional lesion, including stereotactic guidance (performed in a certified ASC or facility surgical suite)	

Excisional, Radiological Marker, Ultrasound Guidance

CPT CODE	Code Descriptions	Billing Guidelines
19125	Excision of breast lesion, identified by preoperative placement of radiological marker, open, single (performed in office or treatment room)	• 19125 may be billed only once per breast, regardless of the number of lesions • 19126 may only be billed for up to 2 additional lesions • Cannot bill with 76645, 76942, or mammogram codes • For 19125/19125F - Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are NOT payable (Global fee period 090). For 19126/19126F -Codes related to another service are always included in the global period of the other service (Global fee period ZZZ) • Use 19125FF to bill for the facility fee when 19125F performed in a certified ASC or a facility surgical suite • 76098 may be billed if indicated for each lesion, up to the maximum of 3 • 88305 may be billed for up to 3 biopsy specimens per breast • ANESTH may be billed with 19125F
19125F	Excision of breast lesion, identified by preoperative placement of radiological marker, open, single (performed in a certified ASC or facility surgical suite)	
19125FF	*Facility fee*	
19126	Excision of breast lesion, identified by preoperative placement of radiological marker, open, each add'l. lesion separately identified	
19285	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance (performed in office or treatment room)	• May only be billed with excisional biopsy and their associated facility codes. Facility fees are included with the primary procedure code • 19285/19285F may be billed only once per breast, regardless of the number of lesions • Additional lesions may be billed up to a maximum of 2 per breast • Cannot be billed with 19081-19086 or their associated facility codes • Cannot bill with 76645, 76942, or mammogram codes
19285F	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance (performed in a certified ASC or facility surgical suite)	
19286	Each additional lesion, including ultrasound guidance (performed in office or treatment room)	
19286F	Each additional lesion, including ultrasound guidance (performed in a certified ASC or facility surgical suite)	

Radiology

CPT CODE	Code Descriptions	Billing Guidelines
76098	Radiological examination, surgical specimen	• May be billed to reflect each lesion present, up to the maximum of 3 per breast
76098TC	*Technical component*	
76098PC	*Professional component*	
76942	Ultrasonic guidance for needle placement, imaging supervision & interpretation	• May be billed to reflect each lesion present, up to the maximum of 3 per breast
76942TC	*Technical component*	
76942PC	*Professional component*	

Pathology

CPT CODE	Code Descriptions	Billing Guidelines
88305	Surgical pathology, gross & microscopic exam	• See individual procedures for guidelines for pathology • Multiple specimens may be included in each cassette. Billing is by cassette NOT by specimen • Lab work prior to biopsy is not payable by EDW
88305TC	*Technical component*	
88305PC	*Professional component*	
88307	Surgical pathology, gross & microscopic exam requiring microscopic evaluation of surgical margins	
88307TC	*Technical component*	
88307PC	*Professional component*	
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	
88331TC	*Technical component*	
88331PC	*Professional component*	
88332	Pathology consultation during surgery, each add'l tissue block with frozen section(s)	
88332TC	*Technical component*	
88332PC	*Professional component*	

Anesthesia

CPT CODE	Code Descriptions	Billing Guidelines
ANESTH	General anesthesia	• See individual procedures for guidelines on anesthesia • Anesthesia can only be billed for procedures performed in an certified ASC or facility surgical suite